OVERVIEW OF INTERNATIONAL TRENDS IN MEDICAL CARE*

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IN the past year I visited Australia, New Zealand, Great Britain, Sweden, and Canada, and spent considerable time looking at their medical schools and examining their medical care arrangements. I found the health needs and expectations of the people of these countries to be remarkably alike but, despite this similarity, the structural forms of their health services were quite different. The principal value in taking a firsthand look at these diverse arrangements is the improved perspective and clearer focus it gives to what one sees when examining the health care system in our own country.

The purpose of my visit was to observe the relationships between the organization of medical care and medical education, especially at the graduate level. I had two primary reasons for making such an inquiry. The first reason had to do with the major changes now taking place in our health care system—changes resulting from strong social forces not peculiar to this country alone—changes that will surely influence the clinical setting in which medicine will be taught. The second reason was the concern I felt over the growing imbalance between specialism and general practice in this country. The medical schools, including my own, are contributing to this imbalance, but we have not found an effective way to change the situation. Our graduates at Baylor University College of Medicine are not unique in seeking specialty training—85 per cent of all United States medical graduates do so. Contributing strongly to the trend toward specialization are the rapid advances in medical knowledge, the nature of the clinical experience students acquire in our teaching hospitals, and the more secure position enjoyed by the specialist in obtaining hospital practice privileges.

The time available to me in each of the countries I visited varied

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from 1 to 4 weeks, scarcely enough to become conversant with the many diverse aspects of health care organization. However, with the kind assistance of knowledgeable persons I was able to identify some of the more prominent elements influencing the development of specific programs and to appreciate the interplay of economic, cultural, professional, and educational factors.

I was struck by the fact that none of these countries any longer has charity hospitals. The institutions that had formerly served this purpose had become general hospitals with the introduction of a universal health insurance or comprehensive social security schemes. The hospitals, for the most part, still have large open wards built on the Florence Nightingale pattern, but are neat and well lighted and serve the general public very well. Funds for construction of new hospitals are becoming available and new hospital designs are being adopted.

Australia, alone, has a voluntary system of health insurance but, like the others, it requires direct government subsidy. The insurance schemes are quite similar in that they all offer hospitalization without charge. They vary greatly, however, in administrative arrangements for meeting hospital costs. In great Britain and New Zealand almost all hospital funds come from the central government; local boards of trustees manage the hospitals, but their authority over finances is limited. Canada and Australia are alike in that funds allocated to the states or provinces from the federal government are distributed through state agencies to the local hospitals. Sweden follows a very different pattern. The local district, corresponding to our county, devotes about 80 per cent to 90 per cent of the taxes it collects to the support of health care. The federal government provides advice and guidance, but decisions are made locally as to where hospitals shall be built, what they shall contain, and how they shall be operated. The hospitals are well managed, and the people are highly satisfied. Teaching hospital costs there are largely borne by the federal government, which supports all higher education.

One finds that medical benefits for patients while in *hospital* are almost wholly covered by the health care scheme. Ambulatory medical benefits vary, however, in that medical services are free in some countries as, for example, Great Britain, while others require additional payments by the patient to the physician. Ordinarily if the patient is a pensioner—i.e., receiving assistance from the government for basic living expenses—he is not required to make additional payments.

In New Zealand the medical benefit is designed to favor the general practitioner; in Australia the insurance benefit cannot be more than 90 per cent of the physician's charge. Canada is in transition, for the government has announced a nationwide system of medical benefits but has postponed implementation until 1967 or 1968. Saskatchewan has already adopted a provincial plan of compulsory medical insurance over the severe objection of the medical profession—peace, however, reigns for the moment.

Pharmaceutical benefits are free in Great Britain and New Zealand. In Australia patients pay the first 50 cents of the cost of a prescription.

Understandably, the average person reacts favorably to measures such as these, as they relieve him of worry and concern about the payment of hospital and medical bills. This reaction of the public was epitomized in a conversation I had with the cabdriver who took me to the Waikeri Hospital in Dunedin, New Zealand. He judged from my accent that I was an American and by my destination that I was a physician. I tried to get more than full value for my fare by questioning him about his reaction to the medical care he received under social security. He said this: "We get *good* care. If I go to a doctor I may have to pay him 3 or 4 bob in addition to what he gets from the government, but if I get sick and go to the hospital it won't cost me a farthing. I'll lose my wages but I won't have either a doctor bill or a hospital bill to worry about." Then he looked slyly over his shoulder and said, "I hear this really is a worry in the United States! I've got six kiddies and if they get sick it would set me back a pretty penny to pay for their care if we didn't have socialized medicine. I hear your people are worried about socialized medicine. All I can say is they have nothing to fear." This worthy hackman may not know whether his medical care is good or bad. He has no way of judging whether the long-range health policies adopted by his country will lead to improved medical standards or poorer ones. But he will support with his vote the politician who pledges to maintain or increase his health benefits and will oppose anyone who tries to take them away.

Imposition of governmental restrictions, especially on hospital budgets, can be frustrating to administrators, board members, and physicians. Decisions are always made by people but the basis for restrictive decisions may be either political expediency or the operation of the principle of administrative uniformity. Professor John Beck is physician-

in-chief to the Royal Victoria Hospital in Montreal. In a recent paper delivered to physicians from the United States he made these comments about the "dangers inherent in the medico-socio-economic changes taking place in Canada . . . as seen through the eyes of a departmental head."

> Perhaps first and foremost is the increasing governmental control of medical education and clinical care. . . .
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> Failure of government to recognize special financial needs of teaching hospitals above and beyond those of community hospitals.
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> Failure of government to supply and of the public to understand the need for funds for construction and equipment of new facilities and the improvement of existing areas, including those for training of paramedical personnel. . . .
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> An inadequate supply of patients for teaching at all levels. This entails, in the most gloomy outlook, the complete disappearance of out-patient clinics. . . .
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> Continued pressure for an increased output of physicians, with over-all reduction in quality, emanating not only from government but also from the medical profession at large, the latter because of an increased work load. . . .
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> Failure to provide realistic house officer salaries. . . .
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> Failure of the government to support adequate numbers of full-time teachers. . . .
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> Failure by government to insist on maintenance of a differential fee structure for specialist and general practitioner services. . . .
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> An ever widening gap between supply and demand for health personnel. . . .
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> The greatest danger . . . concerns the expense of such programs to the public purse and the inevitable competition for the tax dollar. The expensive investment required to supply facilities for education and research proffers little political advantage whereas diversion of funds for personal health services is a major political weapon.[1]

Professor Beck may betray excessive concern in his comment, but he is a thoughtful person, and his observations confirm many remarks made to me by academic persons around the world.

The main difficulty with governmentally supported health services, however, is a much graver problem than administrative inadequacy or even political expediency. When a new health care system is put into

effect there is little time or opportunity to change the existing mechanism for the delivery of health services, and it must be imposed upon an arrangement likely to have grave defects. Dr. Gordon McLachlan, of the Nuffield Provincial Hospitals Trust, London,[2] puts it this way: "In the health *service* field, accurate relevant information, scientifically compiled, about the quality and scale of medical care needed, regrettably, is still wanting. It would, of course, be idle to suggest that policies should wait on the results of empirical research; but it is important to get into focus the perspective of needs and priorities for change. Thus even if the structural panaceas which are from time to time dreamt up, were accepted, and brought into being immediately, the fact by itself would contribute little to answering the universal and perplexing questions relating to the reality of the times—i.e., the deployment of skills and money available, and the establishment of policies concerned with the rate and direction of the development of health services in totally different kinds of areas."

My inquiry into the relationship of general to specialty practice yielded some interesting but not very helpful information. The problem of general practice is a universal one. Everyone wishes that more interest would be shown in the field by young medical graduates, but little is offered in the way of definitive training or prestige and status for those who do enter it. What happens, therefore, to bring new medical graduates into general practice is more the result of economic and administrative forces than of educational, scientific, or social influences.

Great Britain has a roughly equal division between general practitioners and specialists. The salaried positions in the hospital system are restricted in number and are open only to specialists. A little less than half the graduates of the medical schools can be accommodated in such positions. Intensive training for a period of 7 to 8 years is required to secure full specialty status and appointment to a consultantship. A young physician may spend 3 to 4 of these years taking additional training and passing the examination of one of the Royal Colleges before he knows for sure that he will obtain a senior registrarship, which is the door leading to consultantship. Unsuccessful candidates have virtually no alternative but to go into general practice or to emigrate. General practitioners are paid on a capitation basis and, with panels of 2,500 to 3,500 patients, earn an average of $7,000 to $9,000 per year. Consultants start at a salary of about $12,000 and may earn, through confidential merit

ratings, up to twice that amount. The discrepancy in financial incentives offered to physicians is a stimulus to secure specialty training. For those who do enter general practice there are few inducements, other than the physician's own sense of personal obligation, to improve his knowledge or to raise his standard of practice.

In Australia and New Zealand, on the other hand, the economic arrangements clearly favor the general practitioner. Surgical specialists make a reasonably good living, but specialists in medicine and pediatrics have a most difficult time and may end up by practicing general medicine; some emigrate to Great Britain or to the United States.

Seventy per cent of Sweden's physicians practice in hospitals. This includes house officers and full-time salaried specialists. Young physicians spend an average of 4 years in hospitals after graduation, and most of them hope for a permanent salaried appointment. Of those who go into private practice, most practice as specialists, many in 12- to 15-man clinics. Relatively few become general practitioners but of those who do many serve also as salaried district health officers performing both public health functions and caring for patients at the rates established by the compulsory health insurance system.

Sweden is the one country where I found the proportion of general practitioners to be less than in the United States. In response to a recent governmental decision the faculties of the six universities have set about the task of doubling medical graduates by 1975. The sharp increase in physicians will undoubtedly increase the ratio of general practitioners to specialists.

The situation in Canada is much the same as in the United States. About 60 per cent of physicians are specialists and about 75 per cent to 80 per cent of graduates seek training for a special field.

One may say, therefore, with some confidence that, in the absence of external controls, medical graduates today will pursue specialty practice in preference to general practice. Those who do go into general practice have an uncertain medical future. Most, except in Australia and Canada, will have no hospital privileges and will be handicapped in keeping abreast of medical advances. Hanging over the general practitioners of Commonwealth countries is the shadow of the capitation system that Great Britain has adopted. The fear is that labor governments, which are in general opposed to fee-for-service medical practice, will put pressure on the medical profession. It is anticipated that the special-

ists in such a circumstance will "cave in" and will accept full-time salaried hospital positions, leaving the general practitioner vulnerable to imposition of the despised capitation system. This underlying fear may well account for the subtle resistance on the part of organized medicine in Australia and New Zealand to changes that would ameliorate the less than satisfactory arrangement under which the specialist works.

Having looked at the broad aspects of the financial and professional elements in the organization of medical care in these several countries, we might now find it useful to get some judgment of the quality of what has been accomplished. Sir Douglas Robb, a thoracic surgeon and now chancellor of the University of Auckland, reviewed several years ago the development of health services in New Zealand, the first of these countries to adopt a universal health scheme. He says in his general evaluation, "The whole thing, in every particular, has been an exercise in supplying services [in novel ways] to the people. [We have seen] why the emphasis was on service and why those planning it were unable or unwilling to include in their view any serious consideration for quality. Medical, hospital, other services were going on—let us make them free or more generally available. No question was asked whether they were worth having as they were or whether they could be made better. The politician had to get into office and stay there, and official medicine had to secure the best bargain it could. It was not, as might be ideally hoped, an opportunity for an all-around review and improvement. The old wine was to be distributed in new bottles—let the purveyors of the product take care of its quality at their own expense.

"Whether any country as it bends itself to the seemingly inescapable task of providing smaller or larger doses of state medicine will ever be able to look at it more constructively is doubtful. Certainly New Zealand did not and has not yet done so 20 years later. Any important reform or betterment must still come up the hard way through enlightened and tenacious individuals or institutions which are most unlikely to be paid to think it out or provide it."[3]

Sir Douglas' judgment of state medicine may be factually correct but the picture is not quite so universally depressing as he makes it out to be. The quality of hospital medicine in both Great Britain and Sweden is high. The main difficulty is the waiting period for elective procedures. Unfortunately the quality of general practice is not of the same standard.

Investigators in many countries, aware of the lack of quality controls, are now actively engaged in health care research. They are acquiring a body of factual information about the distribution of medical services, including the incidence of medical conditions encountered in practice and in hospitals—the extent of both recognized and unrecognized health needs—how physicians work or fail to work with associated health personnel—and information about many other related aspects of the total health care environment. Ultimately information of this kind, when verified and refined, will form a basis for making sound plans and for making equitable adminstrative decisions. One might compare this recent exploration of the relatively new field of medical care research with our early scientific studies, which later came to have such a profound effect on the practice of medicine. The lag in application to ongoing problems is regrettable but inevitable.

Is there any consistent pattern discernible in the varied responses made by these several countries to the health needs of their people that would be of value in our own planning? I doubt that we in this country would wish to adopt any of these schemes, but perhaps we can heed some of the warnings based on the experience they have acquired over the past quarter century—McLachlan has advised us not to rely on "structural panaceas"; Beck has indicated the dangers to medical education of governmental influences that fail to respond to the needs of quality education and research; and Sir Douglas Robb has told us to beware of dispensing the old health care wine in new bottles.

In our response to demands for change we should make intelligent efforts to avoid the dangers to which we have been alerted. Valid reasons exist for expecting that we in this country shall chart our own course, avoiding known rocks and shoals but perhaps encountering new ones:

1) Our economic resources are substantial and we are prepared to use them to establish the highest standard of health care.

2) As a people we have prided ourselves on voluntarism as opposed to compulsion. Both private education and private hospitals have achieved high standards in this country.

3) Our hospital system is strong. It has grown strong through the support of voluntary health insurance, private philanthropy, and a creative, governmentally supported hospital construction act.

4) Our medical schools have developed strong programs of research

and research training, accomplished initially through the effort of private philanthropy but maintained and expanded chiefly by the National Institutes of Health.

Health legislation recently adopted by Congress, rather than portending the imposition of governmentally determined patterns of health care, as feared by some, can instead become the vehicle for modifying the delivery of health services in keeping with the most authentic tradition in the United States. The enactment of Medicare legislation together with Title 19 will relieve voluntary health insurance organizations of a heavy burden of responsibility that they found they could not in any case meet through premiums from subscribers. These organizations are now in a favorable position to experiment with the provision of wider coverage of medical benefits, and with greater standardization of premiums and benefits for both medical and hospital insurance.

The time is now favorable also for the medical profession to cooperate in making prepaid medical care (including x-ray and laboratory examinations) for ambulatory patients more readily available. This step will go a long way toward reducing those hospital costs created by unnecessary hospitalization of patients for diagnostic purposes. Our Blue Shield plans for payment of medical costs have not worked as well as they should because they have not had the full support of the medical profession. In contrast, the Manitoba Medical Service in Canada has shown what can be accomplished voluntarily by a united profession. One hundred per cent of the physicians in that province have signed contracts agreeing, first, that they will limit their charges to subscribers to the schedule of fees adopted and published by the Manitoba Medical Service and, second, that they will accept that share of their total charges, which income from premiums will support. The physicians currently receive an 80 per cent proration of their fees from regularly enrolled subscribers and a 70 per cent proration of fees from pensioners whose premiums are paid by the province. Manitoba Medical Services has enrolled 55 per cent of the entire population in the province.

The full exploration of the possibilities of voluntary health insurance can challenge the best efforts of consumer groups, employers, insurance carriers, hospitals, clinics, and the medical profession. Failure to develop a satisfactory basis for a broadly based and adequate voluntary system will surely result in the adoption of a compulsory one: first for hospitalization, including medical care in hospital, and then for ambulatory

medical benefits.

We can make good the time we have left for experimentation in still another way. In enacting the Regional Medical Program for Heart Disease, Cancer and Stroke and Related Diseases, Congress has put into the hands of the people a means for examining closely the basic health requirements of each region. It has even left to institutions and public and professional representatives the determination of what should constitute a medical region. The opportunity exists to conduct the planning that Sir Douglas Robb doubted would ever be accomplished. We can now identify our current assets in personnel and facilities, and we can establish experimental programs to explore ways of uniting the resources of each region for greater effectiveness. It is significant, I believe, that this program has been made a division of the National Institutes of Health. The tradition of that organization for making awards on the basis of merit will assure that the funds expended will be for projects of scientific value.

Given sufficient hard information about our health needs and resources and given flexibility in determining which programs are effective and which are not, we shall be in a sound position to ascertain whether we can obtain high-quality care for all our people under an expanded system of voluntary health insurance. If it appears that further direct government aid is in fact necessary, we can hope to establish a basis for directing this support in constructive ways that will advance health standards rather than retard them.

We face twin evils: on the one side, a laissez-faire attitude toward health care; on the other, a desire for the imposition of politically sponsored "structural panaceas" to meet the clamor for public support of health costs. We must protect ourselves from both.

We can avoid the dangers to the right and the left only by establishing a rational basis for meeting health needs—a task of no mean proportions. Such a basis will be established, if at all, only by intelligence, persistence, and hard work. A health care system that will serve us well should be consistent with our traditional preference for voluntarism, should stimulate and attract superior people to join the health field, should encourage the advancement of knowledge and, in the end, should result in the highest standard of health attainable.

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